CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050243	A. BUILDING _____ B. WING _____	02/22/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT REGIONAL MEDICAL CENTER	**1150 NORTH INDIAN CANYON DRIVE, PALM SPRINGS, CA 92262 RIVERSIDE COUNTY**

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	E 000 Initial Comments The following reflects the findings of the California Department of Public Health during a Complaint investigation. Complaint Number: CA00141446 On February 22, 2008, at 1:15 p.m., Immediate Jeopardy (IJ) was identified regarding the facility Abuse policies and procedures. The IJ was abated on February 22, 2008, at 4:15 p.m. Representing the Department: [redacted], HFEN The IJ resulted in the potential for serious harm in all patients due to the facility's failure to develop a complete and effective system for conducting thorough investigations into patient allegations of abuse and protecting the patients from further abuse from alleged perpetrators. A 012 1280.1 (a) HSC Section 1280 If a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 receives a notice of deficiency constituting an immediate jeopardy to the health or safety of a patient and is required to submit a plan of correction, the department may assess the licensee an administrative penalty in an amount not to exceed twenty-five thousand dollars ($25,000) per violation. A 014 1280.1 (c) HSC Section 1280			

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Continued From page 1 For purposes of this section "immediate jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient. T22 DIV5 CH1 ART7-70701 (a)(5). Governing Body (a) The governing body shall: (5) Take all reasonable steps to conform to all applicable federal, state and local laws and regulations, including those relating to licensure, fire inspection and other safety measures. Based on observation, patient and staff interviews, record review, and policy and procedure reviews, the Governing Body failed to ensure the facility developed policies and procedures that included a comprehensive investigation and follow-up regarding patient allegations of abuse according to all applicable federal, state and local laws and regulations. Specifically the facility failed to; 1. Ensure the safety of Patient A by failing to conduct a thorough investigation resulting in the facility's failure to identify the alleged perpetrator and creating the potential for abuse towards other patients within the facility. 2. Identify the alleged perpetrator which resulted in further mental anguish and fear in Patient A. 3. Protect Patient A and other patients from further contact with the alleged perpetrator.			

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	Continued From page 2 4. Develop a policy and procedure regarding alleged patient abuse allegations. Findings: An unannounced visit was conducted at the facility on February 22, 2008, at 9:30 a.m., in response to a facility reported incident. The incident involved an allegation of abuse by Patient A. Patient A's records were reviewed on February 22, 2008. Patient A was 54 years old. The patient was admitted to the facility on February 14, 2008, with a diagnosis of chronic obstructive pulmonary disease. Patient A received respiratory therapy treatments secondary to her diagnosis. A review of the nurse's assessment for Patient A, dated February 14, 2008, at 10:30 p.m. was conducted on February 22, 2008. The assessment noted Patient A was oriented to place, person and time. Patient A's speech was indicated as clear. An unusual event report notification of alleged sexual assault on February 15, 2008, regarding Patient A was forwarded to the California Department of Public Health on February 20, 2008. The report indicated Patient A stated, "I want a rape test. The night nurse...put something in my hand and then put my hand to my mouth and I took something. I do not remember anything after that and I feel different down there." The facility's security incident report, dated February 16, 2008, at 7:30 p.m. was reviewed. The			

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	Continued From page 3 reporting officer stated, "A white male with an earring wearing tan scrubs gave her (Patient A) a pill that made her fall asleep." Patient A was observed at the facility on February 22, 2008, at 9:50 a.m., lying in a hospital bed. The head of the bed was elevated. The patient was awake and alert, her speech was clear. Patient A was questioned regarding the incident that she reported to staff on February 15, 2008, (time not indicated). Patient A stated the same man entered her room last evening. The patient stated, "He was my respiratory therapist. He said, are you going to be good? I said I am not bad, I am sick." Patient A further stated she became fearful and stated(referring to the incident on February 15, 2008), "There were no fluids on me, like after sex, only a dryness." Patient A was interviewed again on February 22, 2008, at 12:50 p.m. Patient A stated, "I asked for a pelvic exam at the time, I have not had one yet, they (the facility) did not ask me if I wanted one, it would clear up a lot of questions." An interview was conducted on February 22, 2008, at 10:15 a.m. with the registered nurse (RN) taking care of Patient A. The RN stated, "I had her, (Patient A) on February 16, 2008. I made my assessment at 7:45 a.m. The patient evidently was upset all night, nothing was right, she was ranting and raving, very anxious. I gave her an ativan (sedative medication). The supervisor came up and sat with her. She wrote the unusual occurrence (event) report."			

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	Continued From page 4 An interview was conducted with the infection control nurse (ICN), on February 22, 2008, at 10:30 a.m. The ICN was questioned regarding which staff had been involved in the care of Patient A on February 15, 2008. The ICN stated a male respiratory therapist (RT) worked with Patient A on February 15, 2008. An interview was conducted with the ICN on February 22, 2008, at 11 a.m. The ICN stated, "I am not able to give you this (referring to a facility internal) document, but I can read it to you, "The supervisor spoke to the charge nurse (regarding the incident involving Patient A), no male nurse or certified nurses assistant worked with the patient. The supervisor notified Patient A's physician, who said to follow hospital protocol." The ICN further stated that it appeared only nurses were suspected by the facility to have been involved in the incident. An interview was conducted with the ICN on February 22, 2008, at 11:45 a.m. The ICN stated, "No one addressed the respiratory therapist's presence." Interviews were conducted on February 22, 2008, at 11:50 a.m. with the coordinator of the pulmonary department (CPD) and the director of the pulmonary department (DP). The DP, (with regard to the suspected individual who gave the respiratory treatment to Patient A on February 15, 2008,) stated one of his staff fit the description and , "...has a pierced ear." The CPD stated, "If we would have known we would have had an investigation, we			

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	Continued From page 5 would have interviewed the patient. Human resources would have been notified." "It looks like no one thought about respiratory therapy." An interview was conducted with the ICN on February 22, 2008, at 12:15 p.m. The ICN stated, "There is no policy or procedure regarding patient allegation of abuse." The federal regulation, 42 CFR 482: Conditions of Participation for Hospitals indicates according to 482.13 A (c) (3): A. A hospital must protect and promote each patient's rights (c) standard: Privacy and safety. (3) The patient has the right to be free from all forms of abuse or harassment. The hospital's failure to conduct a thorough and complete investigation surrounding Patient A's allegation of abuse, failed to protect or promote the patient's right to be free from all forms of abuse. On February 22, 2008, at 1:15 p.m., the ICN and the chief nursing officer were notified that an Immediate Jeopardy was identified as the facility failed to have a system in place to ensure that patients admitted to the facility, including Patient A, were protected after alleged incidents of abuse were reported. There was no policy or procedure in place for staff to follow regarding allegations of abuse by a patient. The facility failed to conduct a thorough investigation of all staff who provided care to Patient A and failed to have a system in place to address patient allegations of sexual assault by a facility employee which included protection of the patient,			

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	Continued From page 6 conducting a thorough investigation, followed by an appropriate action and response. These failed practices resulted in compromised patient safety. On February 22, 2008, at 4:15 p.m., an acceptable plan of correction was received and the Immediate Jeopardy was abated in the presence of the director of quality management.			

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